

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 40402

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		Registrar's No. 2036	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Russell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>243 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Russell</u>		8157	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VA Hospital</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Paul</u>		b. (Middle) <u>D.</u>		c. (Last) <u>SIDEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 23, 1950</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>January 8, 1892</u>	
9. AGE (in years last birthday) <u>58</u>		10. UNDER 1 YEAR Months		11. UNDER 1 YEAR Days		12. UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Hot Springs, So. Dakota /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John F. Sidey</u>		13b. MOTHER'S MAIDEN NAME <u>Gertrude L. Racon</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA Hospital Records, Springfield, Missouri</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis, pulmonary, far advanced, active</u> INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Silicosis</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 24</u> , 19 <u>50</u> , to <u>Dec. 23</u> , 19 <u>50</u> , that death occurred at <u>5:12P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Paul L. Eisele</u> Chief (Degree or title)				23b. ADDRESS <u>VA Hospital Springfield, Missouri</u>		23c. DATE SIGNED <u>12/24/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec 29, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>12-27-50</u>		REGISTRAR'S SIGNATURE <u>W. E. Houdley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeizer</u> ADDRESS <u>Springfield, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed..... *Bernard F. Wright*

Licensed Embalmer No. *4293*

P. O. Address *Springfield,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.